


IHA Health Plan: 3,500 Plan Option

Coverage for: All Coverage Levels | Plan Type: Traditional

 Subject to plan allowable **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.myperformancehlth.com](http://www.myperformancehlth.com) or call 1-877-585-8480. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform.com](http://www.dol.gov/ebsa/healthreform.com) or [www.cciio.cms.gov](http://www.cciio.cms.gov)

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Deductible \$3,500/individual or \$7,000/family	Generally, you must pay all the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see chart starting on page 2 for other costs for services this plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	OOP \$7,350/individual or \$14,700/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balanced-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	No network restrictions.	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$45 <a href="#">copay</a> /visit	Subject to plan allowable
	<a href="#">Specialist</a> visit	\$90 <a href="#">copay</a> /visit	Subject to plan allowable
	<a href="#">Preventive care/screening/immunization</a>	0% coinsurance	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Subject to plan allowable
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (blood work)	20% after deductible	Subject to plan allowable
	Imaging (X-Ray, CT/PET scans, MRIs)	20% after deductible	Subject to plan allowable
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mycigna.com">www.mycigna.com</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription	<a href="#">Copays</a> listed are for 0-30 day supply/prescription. 31-90 day supply; generic \$45.00, brand name \$90.00, Non-Preferred Brand \$150.00  <a href="#">Copays</a> apply to Retail and/or Mail Order.
	Preferred brand drugs	\$65 <a href="#">copay</a> /prescription	
	Non-preferred brand drugs	\$100 <a href="#">copay</a> /prescription	
	<a href="#">Specialty drugs</a>	Excluded	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.
	Physician/surgeon fees	20% after deductible	Subject to plan allowable
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% after deductible	Subject to plan allowable
	<a href="#">Emergency medical transportation</a>	20% after deductible	Subject to plan allowable
	<a href="#">Urgent care</a>	\$90 <a href="#">copay</a> /visit	Subject to plan allowable

[\* For more information about limitations and exceptions, see the plan or policy document at [www.myperformancehlth.com](http://www.myperformancehlth.com)

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% after deductible	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.
	Physician/surgeon fees	20% after deductible	Subject to plan allowable
<b>If you need mental health, behavioral health and substance abuse services</b>	Outpatient services	\$45 <sup>copay</sup> /visit	Subject to plan allowable
	Inpatient services	20% after deductible	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.
<b>If you are pregnant</b>	Office visits	20% after deductible	Subject to plan allowable
	Childbirth/delivery professional services	20% after deductible	Subject to plan allowable
	Childbirth/delivery facility services	20% after deductible	Subject to plan allowable
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% after deductible,	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.
	<a href="#">Rehabilitation services</a>	0% after copayment, per visit	Limited to 20 visits per Calendar Year for physical, and occupational therapies each, 20 visits for Speech, 15 visits for Chiropractic. Subject to plan allowable
	<a href="#">Habilitation services</a>	0% after copayment, per visit	Limited to 20 visits per Calendar Year, combined with the above therapies. Subject to plan allowable
	<a href="#">Skilled nursing care</a>	20% after deductible	Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable
	<a href="#">Durable medical equipment</a>	20% after deductible	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.  (Limited to 12 month rental or purchase price, whichever is less)
	<a href="#">Hospice services</a>	20% after deductible	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.myperformancehlth.com](http://www.myperformancehlth.com)

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatments</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Durable medical equipment</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Performance Health at 877-585-8480 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [877-585-8480]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [877-585-8480]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[877-585-8480]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [877-585-8480]

---

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

---

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist](#) [*cost sharing*] \$90
- Hospital (facility) [*cost sharing*] 0%
- Other [*cost sharing*] 0%

This **EXAMPLE** event includes services like:  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$3,580</b>
---------------------------	----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,590</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist](#) [*cost sharing*] \$90
- Hospital (facility) [*cost sharing*] 80%
- Other [*cost sharing*] 0%

This **EXAMPLE** event includes services like:  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$1,000</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$90</b>

**Mia's Simple Fracture**  
(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist](#) [*cost sharing*] \$90
- Hospital (facility) [*cost sharing*] 0%
- Other [*cost sharing*] 0%

This **EXAMPLE** event includes services like:  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$3,500</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,590</b>